REQUEST

FROM: (Requesting physician or act...) | DATE OF REQUEST

Orthopedic Surgeon | Dennis Olson, MD, CHP | 7/17/01

...ON FOR REQUEST (Complaints and findings)

C/O LBP → (R) leg

...VISIONAL DIAGNOSIS

(1) LBP - R/O radiculopathy

...ER'S SIGNATURE	APPROVED	PLACE OF CONSULTATION		
Dennis Olson, MD		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ 72 HOURS	☐ TODAY ☐ EMER...

D. OLSON, MD

CONSULTATION REPORT

...CORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

S: 48 y/o 007 c 2½-3 wks severe (R) leg pain c swelling lower extremity. c/o diffuse paresthesia of (R) lower leg; denies back pain, symptoms appeared suddenly s injury ~2 wks ago one am; c/o inability to lay on (L) side.

O: ⊖ SLR ⊖ calf tenderness, diffuse paresthesias of (R) lower extremity no involving foot (non dermatomal). no palpable DP; non palpable TP pulses; nl motor strength EHL, plantar flexors, dorsiflexors.

Xrays: lumbar spine: nl lordosis mild degenerative dz; well preserved disc spaces out osteophytes c mild degenerative disc dz L2-3 level

A: vascular vs neurologic claudication

P: (1) needs vascular studies of (R) lower extremity
(2) consider EMG/NCV (R) lower extremity
(3) consider Trental
(4) analgesics for pain

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

[signature] 7-31-01

IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD
	FCI MCKEAN HEALTH SERVICES	07928-078	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Cheng, Darryl

Reviewed by D. Olson, MD
Date: 7/31/01

CONSULTATION S...
Medical Reco...

000160

CONSULTATION SHEET

REQUEST

Dr. Christian Howard

FROM: (Requesting physician or activity) Dennis Olson, MD, CHP

DATE OF REQUEST

Eye Exam

SUBJECTIVE:

left eye weak
wears drug store glasses
age 47

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ D. OLSON, M.D.

CONSULTATION REPORT

PATIENT EXAMINED ☑ YES ☐ NO

VISUAL ACUITY Distance OD 20/20 OS 20/150

TONOMETRY: OD ____ OS ____

Near OD 1.5 m OS 2.5 m

EXTERNAL Normal 77/73

INTERNAL Media clear, fundus normal CD = .3/.3

REFRACTION OD +1.00 -.50 x 95 20/20 .37 m 7 H.50
OS +4.00 — 20/50 .62 m

52 - 24 x 6 1/4
18

DIAGNOSIS CHA & presbyopia
anisometropia
amblyopia OS

ANALYSIS requires prescription lenses
PLAN Pass to BOP Rx bifocals for full-time wear

(Continue on reverse side)

SIGNATURE AND TITLE Christian J. Howard OD

DATE 12/13/10

IDENTIFICATION NO. ORGANIZATION FCI Mckean

REGISTER NO. 07928-078

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Cherry, Darryl

R 12/15/00

D. Olson, MD
Clinical Director

CONSULTATION SHEET
Medical Record

STANDARD FORM 513

000161

MEDICAL RECORD — CONSULTATION - REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
OPTOMETRY	Dennis Olson, M.D., CD	

REASON FOR REQUEST (Complaints and findings)

EYE EXAM chronic HCV

SUBJECTIVE:

Did not appear for scheduled appointment

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
Dennis Olson MD D. Olson, MD Clinical Director		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☒ NO

VISUAL ACUITY Distance OD OS TONOMETRY: OD

Near OD OS

EXTERNAL

INTERNAL Failed to keep appt

REFRACTION

DIAGNOSIS 9/14/10

ANALYSIS

PLAN D. Olson, MD
Clinical Director

(Continue on reverse side)

SIGNATURE AND TITLE		DATE
Christian J. Howard MD		9/13/05
IDENTIFICATION NO.	ORGANIZATION: FCI McKean	REGISTER NO. 07728-078 / WARD NO.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)*

Cherry, David

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-5

CHERRY, Darryl
Reg. No.: 07928-078
MCK 326198-F2

PART B-RESPONSE

This is in response to your Request for Administrative Remedy receipted in my office on February 19, 2004, in which you claim you are not receiving appropriate medical care for hepatitis C. Specifically, you request a liver biopsy and treatment with interferon and ribaviron.

An investigation of your complaint reveals you were diagnosed with hepatitis C, and placed on chronic care clinic, July 26, 2000. You are evaluated by the medical officer every three months at chronic care clinic. You are educated as to your condition at each clinic visit. The health services unit follows guidelines set forth by the medical director of the Bureau of Prisons for the treatment of hepatitis. You currently do not fit the guidelines to obtain a liver biopsy or receive medication. You will continue to be evaluated at regular intervals on clinic. If you experience problems with your health between clinic visits you may sign up for sick call.

Based on this information, your Request for Administrative Remedy is denied.

In the event that you are not satisfied with this response, you may appeal within twenty (20) calendar days from the date of this response by submitting a BP-DIR-230 to the regional director.

3/25/04
Date

S S Rolvare for
James F. Sherman, Warden

LOU SENSITIVE

000163

ADMINISTRATIVE REMEDY REQUEST

CHERRY, Darryl
#07928-078

01-30-2004

This is in response to your administrative remedy request where you claim you are not receiving the proper medical treatment for hepatitis C, which you have been diagnosed as having. Specifically, you feel you should be treated with interferon and a liver biopsy should be performed.

An investigation was conducted and the appropriate staff were contacted regarding this issue. Health Services staff reviewed your medical chart and determined that you are being treated in accordance with Federal Bureau of Prisons recommendations for hepatitis C. Your liver function test results indicate normal-to-slightly elevated levels. Therefore, the risks of a liver biopsy and treatment with interferon, outweigh the potential benefit. Your next chronic care appointment is scheduled for 02-04-2004 at 12:30.

I trust this addresses your concern.

If in the event you are not satisfied with this response, you may obtain a BP-9 from your counselor for a response from the warden.

L. Morello 01-30-04

FEDERAL BUREAU OF PRISONS

memorandum

FCI McKean, Pennsylvania

DATE: March 15, 2004

REPLY TO ATTN. OF: Rosemary Dean, Warden's Secretary

SUBJECT: Administrative Remedy (BP-9)
MCK 326198-F2

TO: Rodney Smith, HSA

Please investigate the attached Request for Administrative Remedy (BP-9) filed by inmate **CHERRY, Darryl, Reg. No. 07928-078.** Route your response through your associate warden and the camp administrator/legal liaison. Your response is due in the warden's office no later than **March 22, 2004.**

LOU SENSITIVE

MAR-08-2004 10:25 FROM: TO:814 837 9661 P.001

PHARMACY TECHNICAL REFERENCE MANUAL
7/28/99 PART 1 - NATIONAL FORMULARY

TRM6501.05
Section 9, Page 1

PLEASE TYPE OR NEATLY PRINT ALL INFORMATION IN SECTION I

*** NON-FORMULARY DRUG AUTHORIZATION ***

I PATIENT NAME Cherry, Darryl ID NUMBER 07928-078
REQUESTOR Labrozzi/Beam INSTITUTION FCI McKean

DRUG REQUESTED Eucerin
Generic Brand

DOSE AND REGIMEN Apply to regions of healing stasis ulcers BID

DATE REQUESTED 3/5/04 EXPIRATION OF ORDER 90 days

DIAGNOSIS Venous insufficiency → stasis ulcers
(Ulcers are virtually healed. We believe, based on experience & other inst. with same Dx, that Eucerin application will aid recurrence + improve skin health)

REASON(S) WHY FORMULARY AGENT(S) CANNOT BE USED:
- All emollients are non-formulary
- Pt is on extended restriction from Commissary.

FORMULARY AGENT(S) TRIED:

COST OF THIS THERAPY:
$ 2.16 / 4oz. jar.

COST OF FORMULARY AGENT:

J. BEAM, MD
KEN MCKEAN
CLINICAL DIRECTOR — Date 3/8/04

INSTITUTION PHARMACY COMMENTS:

PHARMACIST — Date 3/8/04.

II BOP CHIEF PHARMACIST COMMENTS:
Commissary restriction should not include OTC meds

CHIEF PHARMACIST — Date

MEDICAL DIRECTOR COMMENTS:

APPROVED: for Christopher Bina — Date 3/8/04
MEDICAL DIRECTOR, BOP
Newton E. Kendig, MD

DISAPPROVED: _____ — Date _____
MEDICAL DIRECTOR, BOP
Newton E. Kendig, MD

PAGE ____ OF ____
FROM: Violetta Geza, PharmD
TITLE: Chief Pharmacist
INSTITUTION: FCI McKean
PHONE #: (814) 362-8900 x3480
FAX#: (814) 363-6813
TO: CHIEF PHARMACIST, BOP
PHONE #: (202) 307-2867
FAX#: (202) 305-0862

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 98
U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) MEDICAL STAFF DR. BEAM	DATE: 10/13/03
FROM: DARYL CHERRY	REGISTER NO.: 07928078
WORK ASSIGNMENT: ORDERLY	UNIT: A, B,

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, You will be interviewed in order to successfully respond to your request.)

IT HAS BEEN DOCUMENTED THAT I HAVE HEPATITIC C, SINE 7/26/2000 IT'S POSSIBLE THAT I MAY HAVE HAD THIS DISEASE FOR MORE THAN 20 YEARS. I HAVE ELEVATED ALT LEVELS AND ON AT LEAST ONE OCCATION GREATER THAN TWICE THE UPPER LIMIT OF WHATS CONCEIR NORMAL. ALT LEVELS ARE A INDICATOR OF LIVER INFLAMATION AT THE TIME OF THE TEST, BUT DO NOT GIVE A COMPREHENSIVE PICTURE OF LIVER DAMAGE. BILIROBIN ALBUMIN ARE TRUE LIVERS FUNCTION TESTS, CLOSE TO THESE TEST INDICATE THAT'S ONES LIVER IT'S NOT WORKING PROPERLY. WHEN THESE RESULTS BECOME ABNOMAL IT'S LIKELY THAT SCARRING AND POSSIBLY EARLY STAGES OF CIRRHOSIS CAUSED BY HEPATITIS C DISEASE HAS BEGUN ALSO CONSISTENT ELLEVATION OF GGT IT'S A SIGN OF LIVER PROMBLEM,

(Do not write below this line)

DISPOSITION: (1) The next time you are here on chronic care clinic we can talk more about your concern. If it is time for a liver Biopsy and treatment it will happen

(2) Come to sick call for dressing supplies for your ankle

Signature Staff Member H. BEAM, MD FCI MCKEAN | Date 10/15/03

Copy - File; Copy - Inmate
This record Form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

SUCH AS Problems with my Bile Duct Request THAT A
LIVER Biopsy BE done to determine THE HEALTH of my LIVER,
And if Fibrossi is forming. Requested THAT I BE treated,
FOR my liver Disease, instead of just monitering.
ALSO REQUEST to BE VACCINATED AGAINST HEPATITIS A

THANK YOU

PLEASE RESPOND

ALSO I NEED SUPPIES BAD my LEGS BREAKING DOWN BAD.

BP-S148.055 INMATE REQUEST TO STAFF CDFRM
SEP 99
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) Director Beam	DATE: 10-16-03
FROM: Daryl Cherry	REGISTER NO.: 07928-078
WORK ASSIGNMENT: orderly	UNIT: AB

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

It's Possible that I have had Hepatitis C for more than 20 years All my LAB Results are Abnormal Request to have a liver Biopsy done As ALT levels AINT A TRUE INDICATOR of the Health of my liver. They can't determine IF I have fibrosis or Cirrosis, ALT levels only can tell IF theres INFLAMATION At the time of the Test. And As I previously stated All my Blood tests are Abnormal. Some that would Indicate Fibrosis or Cirrosis. Request To Recive Treatment for My Hep C Disease - And not Just Monitering

(Do not write below this line)

DISPOSITION:

WE CAN review your situation at your next Chronic care clinic

Signature Staff Member H Beam

Date 10/20/03

REVIEWED BY: H. BEAM, MD FCI McKEAN

Original Copy - File; Copy - Inmate
This form may be replicated via WP

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

000169

Printed on Recycled Paper

BP-S148.055 **INMATE REQUEST TO STAFF** CDFRM
SEP 98

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

TO: (Name and Title of Staff Member) Doctor Beam	DATE: 10-16-03
FROM: Daily/ Cherry	REGISTER NO.: 07928-078
WORK ASSIGNMENT: Orderly	UNIT: AB

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.)

Request To be Vaccinated against Hepatitis A According to BOP Policy/ BP-S552.062, Information on Hepatitis A Vaccine. As I have Hepatitis C

(Do not write below this line)

DISPOSITION: You'll be on chronic care clinic within approx 3 wks. we can talk further. I'll check a blood Test for evidence of Hep A infection to see if you need the immunization

Signature Staff Member: H. BEAM, MD FCI MCKEAN

Date: 10/10/03

Record Copy - File; Copy - Inmate
(This form may be replicated via WP)

This form replaces BP-148.070 dated Oct 86 and BP-S148.070 APR 94

Printed on Recycled Paper

(27-330.4)

CASE REPORT

DEPARTMENT OF HEALTH

DISEASE: Hepatitis C | STATE: PA | DATE: 7/26/2000

PATIENT'S NAME: Cherry, Darryl | AGE | M [X] F [ ] | RACE: B | TELEPHONE NO.: 814-362-8900

USUAL ADDRESS (Street No., City, Borough, Township, If Rural Give R.D. and Location)

FCI mc Kean, PO Box 5000, Bradford, PA 16701

COUNTY: McKean | OCCUPATION: Inmate

INFECTIOUS AGENT (If Known) | SITE

LABORATORY DATA: Reactive Hep C Ab

HOSPITAL | DATE ADMITTED

PHYSICIAN'S NAME: Dennis Olson, MD | ADDRESS: (same) | TELEPHONE NO.: (same)

INDIVIDUAL REPORTING: Susan Cyeki, MT | ADDRESS: " | TELEPHONE NO.: "

COMMENTS:

(FOLD INWARD, ALONG THIS BROKEN LINE)

LIST OF REPORTABLE DISEASES

AIDS
Amebiasis
Animal Bites
*Anthrax
*Botulism
Brucellosis
Campylobacteriosis
Cancer
Chlamydia
Trachomatis Infections
*Cholera
*Diphtheria
Encephalitis
*Food Poisoning
Giardiasis
Gonococcal Infections
Guillain-Barre Syndrome
Haemophilus Influenzae
type b disease
Hepatitis, Viral, Including
Type A, Type B, and Type NANB
Kawasaki Disease
Lyme Disease
Malaria
*Measles
Meningitis-All Types
Meningococcal Disease
Mumps
Pertussis
*Plague
*Poliomyelitis
*Psittacosis
*Rabies
Reye's Syndrome
Rickettsial Diseases, Including
Rocky Mountain Spotted Fever
Rubella and Congenital
Rubella Syndrome
Salmonellosis
Shigellosis
*Syphilis-Infectious
Tetanus
Toxic Shock Syndrome
Toxoplasmosis
Trichinosis
Tuberculosis
Typhoid
*Yellow Fever

REPORTABLE ADDITIONAL LABORATORY FINDINGS:

Histoplasmosis
Lead Poisoning
Legionnaires' Disease
Leptospirosis
Lymphogranuloma Venereum
Neonatal Hypothyroidism
Phenylketonuria
Tularemia

**** Immediate Reporting by Telephone or Other Prompt Means***

(AFTER FOLDING, STAPLE CARD AT TOP TO INSURE CONFIDENTIALITY)

U.S. Department of Justice
Federal Bureau of Prisons

Medical Treatment Refusal
(Rechazo de Tratamiento Médico)

10 May 02
Date (Fecha)

I, Cherry, Darryl 07928-078 , refuse treatment recommended by the Federal
(Name and Registration Number) (Numbre y Número de Registro) (rechaza el tratamiento recomendado por el Personal

Bureau of Prisons Medical staff for the following condition(s):
Médico del Bureau Federal de Prisiones, por las siguientes razones):
DESCRIBE IN LAYMAN'S TERMINOLOGY: (DESCRIBA EN TERMINOLOGIA COMUN Y CORRIENTE):

To Stop smoking cigarettes

The following treatment(s) was/were recommended: (El siguiente tratamiento(s) fue/fueron recomendado(s)):

Wellbutrin

Federal Bureau of Prisons Medical staff members have carefully explained to me that the following possible consequences and/or complications may result because of my refusal to accept treatment:

(Los miembros del personal Médico del Bureau Federal de Prisiones me ha explicado cuidadosamente las posibles consecuencias o complicaciones siguientes que pueden resultar por causa de mi rechazo a aceptar tratamiento):

Increased desire to smoke

I understand the possible consequences and/or complications, listed above, and still refuse recommended treatment. I hereby assume all responsibility for my physical and/or mental condition, and release the Bureau of Prisons and its employees from any and all liability for respecting and following my expressed wishes and directions.

(Me doy por enterado de las posibles consecuencias o complicaciones enlistadas arriba, y aun así me rehuso al tratamiento recomendado. Por medio de la presente, asumo toda responsabilidad por mi condición física o mental, y relevo al Bureau de Prisiones y a sus empleados de cualquiera y toda responsabilidad por cause de respectar y seguir mis expresos deseos y direcciones.)

Darryl Cherry 07928078 5/16/002
Patient's Signature and Date (Firma del Paciente y Fecha)

/s/ Bonnie A Seylor 16 May 02
ture of Witness and Date (Firma del Testigo y Fecha)

Witness and Date (Firma del Testigo y Fecha)

nate's Medical Record
spital File
nate

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000172

BP-358(60)
MAY 1985